Stowers fought breast cancer in 1993 followed by years of treatment, and their daughter, Kathleen's current encounter with cancer was the impetus for the creation of the Stowers Institute for Medical Research. Jim Stowers serves as president with Virginia serving as vice president over every aspect of their legacy to scientific research.

The Stowers Institute is attracting the most highly sought researchers in biology, technology, and engineering who want to join in this exciting and worthy venture. World renowned experts from the University of Washington, the California Institute of Technology, the University of California, Berkeley, the McLaughlin Institute, and the University of Missouri-Kansas City are exploring the make-up of our DNA and analyzing the forthcoming information in a facility where research into life systems will produce a better understanding of the nature of cancer. Scientists and doctors would then be able to use this research in developing treatments, medicine, and ultimately, a cure.

Our community has watched the construction of this facility which is anticipated to be in complete operation next year. It rescues from urban blight the site of the former Menorah Hospital near universities and cultural centers. The Stowers endowed to the Institute a gift of $336 million to fund the ongoing research of scientists so they can dedicate their valuable time to science instead to raising money for their work. Investment of the multi-billion dollar assets in mutual funds, contributions by other donors, and the gift of the estate of Virginia and Jim Stowers is expected to reach $30 billion or more in the next millennium, which will secure financial support for the Institute.

Mr. Speaker, please join me in thanking Virginia and Jim Stowers for their tremendous gift, which assures their ongoing mission for ''Hope for Life.'' I look forward to the successes of the Stowers Institute for Medical Research and share the same hope they have inspired.

HIGH-QUALITY CHILD CARE CAN HELP PARENTS MOVE TOWARD SELF-SUFFICIENCY

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 18, 1999

Mr. STARK. Mr. Speaker, I rise to address the issue of quality improvements in our nation's child care centers. As a member of the House Ways and Means Subcommittee on Human Resources with jurisdiction over the federal welfare system, I voted against the 1996 overhaul of our welfare system because of the dangerous effect it would have on the health and well-being of children and families in our country.

Congress was warned by advocates for low-income and poor families that without the proper work supports—health care, food assistance, and child care services—welfare reform's efforts to push mothers into low-paying, low-skill jobs could not succeed. Now as more and more families with children are forced to send both parents (or the only parent) to work, the absence of child care hampers the ability of mothers to successfully make that move.

Families are stuck between a rock and a hard place. Child care is in short supply, is too expensive for many families to afford, and often is of poor quality. When families try to get child care, they encounter long waiting lists—even for crummy programs—or the care available is unaffordable. The message to low-income families is that they must take any care they can get. More often than not, parents end up patching together a number of child care arrangements and go through the day anxious that part of the child care chain will fail. Many mothers are reporting that the child care assigned to them by welfare caseworkers would place their children in a low-quality setting that would make them susceptible to physical harm and do little to prepare children for school.

Working parents need to feel secure about the arrangements they've made for their children during work hours, because the quality of care children receive can make a difference in parents' ability to work. Evaluations of GAIN, the job-training program for welfare recipients in California, found that mothers on welfare who were worried about the safety of their children and who did not trust their providers were twice as likely to subsequently drop out of the job-training program.

We must increase both the quantity and the quality of the care offered. My bill, the Child Care Quality Improvement Act (H.R. 2175), promotes quality child care by providing incentive grants to states to help them set and meet long-term child care quality goals. My bill would base a state's eligibility for future funding on the progress made in increasing training for staff, enhancing licensing standards, reducing the number of unlicensed facilities, increasing monitoring and enforcement, reducing caregiver turnover, and promoting higher levels of accreditation.

Congress has wrongly refused to require significant quality standards for the billions in child care dollars we allocate each year. The federal government should give states the resources to improve child care quality at the local level, but only through a system of measurable indicators of desired outcomes.

As the father of a young son, I know the difficulty families face when searching for a caregiver for their children. I believe we must give families peace of mind by helping states provide the high quality of care every child deserves. We must not threaten a parent's chance at succeeding on the job and achieving self-sufficiency.

OFFERING BODY PARTS FOR SALE

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 18, 1999

Mr. SMITH of New Jersey. Mr. Speaker, I would like to commend to the attention of my colleagues this disturbing article by Mona Charen, which appeared in the November 11, 1999 edition of the Washington Times. As the article itself states, ''This is not a bad joke. Nor is it the hysterical propaganda of an interest group.'' It is comprised of the personal recollections of a medical technician who worked for a medical firm engaged in selling the body parts of the victims of late-term abortions. In her most chilling descriptions, she relates the means by which children born alive are killed, so that their bodies may be sold for profit. On this life and death issue, I urge my colleagues to consider this woman's words for themselves:

[From the Washington Times, Nov. 11, 1999]

OFFERING BODY PARTS FOR SALE

(By Mona Charen)

''Kelly'' (a pseudonym) was a medical technician working for a firm that trafficked in baby body parts. This is not a bad joke. Nor is it the hysterical propaganda of an interest group. It was reported in the American Enterprise magazine—the intelligent, thought-provoking and utterly trustworthy publication of the American Enterprise Institute.

The firm Kelly worked for collected fetuses from clinics that performed late-term abortions. She would dissect the aborted fetuses in order to obtain ''high-quality'' parts for sale. They were interested in blood, eyes, livers, brains and thymuses, among other things.

''What we did was to have a contract with an abortion clinic that would allow us to go there on certain days. We would get a generated list each day to tell us what tissue researchers, pharmaceutical companies and universities were looking for. Then we would examine the patient charts. We only wanted the most perfect specimens,'' That didn't turn out to be difficult. Of the hundreds of late-term fetuses Kelly saw on a weekly basis, only about 2 percent had abnormalities. About 30 to 40 babies per week were around 30 weeks old—well past the point of viability.

Is this legal? Federal law makes it illegal to buy and sell human body parts. But there are loopholes in the law. Here's how one body parts company—Opening Lines Inc.—disguised the trade in a brochure for abortionists: ''Turn your patient's decision into something wonderful.''

For its buyers, Opening Lines offers ''the highest quality, most affordable, freshest tissue prepared to your specifications and delivered in the quantities you need, when you need it.'' Eyes and ears go for $75, and brains for $999. An ''intact trunk'' fetches $500, a whole liver $150. To evade the law's prohibition, body-parts dealers like Opening Lines offer to lease space in the abortion clinic to ''perform the harvesting,'' as well as to ''offset [the] clinic's overhead.'' Opening Lines further boasted, ''Our daily average case volume exceeds 1,500 and we serve clinics across the United States.''

Kelly kept at her grisly task until something made her reconsider. One day, ''a set of twins at 24 weeks gestation was brought to us in a pan. They were both alive. The doctor came back and said, 'Got you some good specimens—twins.' I looked at him and said: 'There's something wrong here. They are moving. I can't do this. This is not in my contract.' I told him I would not be part of taking their lives. So he took a bottle of sterile water and poured it in the pan until the fluid came up over the mouths and noses, letting them drown. I left the room because I could not watch this.''

But she did go back and dissect them later. The twins were only the beginning. ''It happened again and again. At 16 weeks, all the way up to sometimes even 30 weeks, we had live births come back to us. Then the doctor would either break the neck take a pair of tongs and beat the fetus until it was dead.''

American Enterprise asked Kelly if abortion procedures were ever altered to provide specific body parts. ''Yes. Before the procedures they would want to see the list of what we wanted to procure. The [abortionist] would get us the most complete, intact specimens that he could. They would be delivered to us completely intact. Sometimes the fetus appeared to be dead, but when we

opened up the chest cavity, the heart was still beating.''

The magazine pressed Kelly again: Was the type of abortion ever altered to provide an intact specimen, even if it meant producing a live baby? ''Yes, that was so we could sell better tissue. At the end of the year, they would give the clinic back more money because we got good specimens.''

Some practical souls will probably swallow hard and insist that, well, if these babies are going to be aborted anyway, isn't it better that medical research should benefit? No. This isn't like voluntary organ donation. This reduces human beings to the level of commodities. And it creates of doctors who swore an oath never to kill the kind of people who can beat a breathing child to death with tongs.

MEDICARE FRAUD PREVENTION AND ENFORCEMENT ACT OF 1999

HON. JUDY BIGGERT

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 18, 1999

Mrs. BIGGERT. Mr. Speaker, I rise today to introduce the Medicare Fraud Prevention and Enforcement Act of 1999.

The vast majority of health care providers in this country are honest. Yet all large health care programs are vulnerable to exploitation, and Medicare is no exception. Over the past few years, Medicare fraud has skyrocketed, depriving millions of seniors quality care and bilking taxpayers out of literally billions of dollars.

According to the Department of Health and Human Services Inspector General, in fiscal year 1998 alone, waste, fraud, abuse and other improper payments drained as much as $13 billion from the Medicare Trust Fund.

How is this happening? Well, according to a June 1999 General Accounting Office examination of three states—North Carolina, Florida and my home state of Illinois—as many as 160 sham clinics, labs or medical-equipment companies have submitted fraudulent claims.

For example, two doctors who submitted in excess of $690,000 in fraudulent Medicare claims listed nothing more than a Brooklyn, New York laundromat as their office location. In Florida, over $6 million in Medicare funds were sent to medical equipment companies that provided no services whatsoever; one of these companies even listed a fictitious address that turned out to be located in the middle of a runway at the Miami International Airport.

Phony addresses and bogus providers add up to Medicare fraud and taxpayers being swindled out of billions of dollars.

In an attempt to change this equation, I am introducing the Medicare Fraud Prevention and Enforcement Act of 1999. This legislation is designed to prevent waste, fraud and abuse by strengthening the Medicare enrollment process, expanding certain standards of participation, and reducing erroneous payments. Among other things, my bill gives additional tools to the federal law enforcement agencies that are pursuing health care swindlers.

This bill is by no means a solution to Medicare fraud. But the Medicare Fraud Prevention and Enforcement Act of 1999 will make it more difficult for unscrupulous individuals to enter and take advantage of the Medicare system.

It is my hope that, come the next legislative session, my colleagues will join me in making a commitment to preventing and detecting fraud and abuse.

PERSONAL EXPLANATION

HON. ROBERT E. WISE, JR.

OF WEST VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 18, 1999

Mr. WISE. Mr. Speaker, on November 16 and 17, I missed several votes because I was home recovering from surgery. Had I been present, here is how I would have voted on the various bills. I would request that you insert this at the appropriate place in the RECORD.

H.R. 3257, State Flexibility Clarification Act: I would have voted ''aye''.

H. Con. Res. 222, Condemn Armenian Assassination: I would have voted ''aye''.

H. Con. Res. 165, Commend Slovak Republic: I would have voted ''aye''.

H. Con. Res. 206, Express Concern Over Chechen Conflict: I would have voted ''aye''.

H. Con. Res. 211, Support Elections in India: I would have voted ''aye''.

H. Res. 169, Support Democracy and Human Rights in Laos: I would have voted ''aye''.

H. Res. 325, Importance of Increased Support and Funding to Combat Diabetes: I would have voted ''aye''.

Rule to allow suspension bills to be brought up on Wednesday: I would have voted ''no''.

H.R. 2336, United States Marshals Service Improvement Act of 1999—Amends the Federal judicial code to provide for the appointment of U.S. marshals for each judicial district of the United States and for the Superior Court of the District of Columbia by the Attorney General of the United States (currently, by the President), subject to Federal law governing appointments in the competitive civil service: I would have voted ''no''.

H.J. Res. 80, Continuing Resolution: I would have voted ''aye''.

S. 440, Provides Support for Certain Institutes: I would have voted ''no''.

CONGRESSIONAL BLACK CAUCUS VETERANS BRAINTRUST

HON. SANFORD D. BISHOP, JR.

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, November 18, 1999

Mr. BISHOP. The Honorable CORRINE BROWN (D–FL) and I recently convened the 11th Annual Congressional Black Caucus Veterans Braintrust. Traditionally known as one of the highlights of the CBCF Legislative Conference, the Veterans Braintrust has truly become a family affair bringing together African American veterans and supporters from across the nation.

This year's Braintrust forum entitled, ''Veterans Health Care Issues for 2000 and Beyond'' convened with the hope of facilitating a national dialogue between the veterans community and lawmakers. The Braintrust addressed the future course of the veterans health care system with an emphasis in planning for the needs of an aging veterans population. The moderator, Dr. Lawrence Gary, a preeminent scholar from Howard University, led a distinguished panel of experts that included doctors, researchers, government officials, veterans service representatives and community advocates. Participants at the event included: Dr. Eugene Oddone, Dr. Jeff Whittle, Georgia State Senator Ed Harbison, Dr. Sissy Awoke, Mr. Charles McLeod, Jr., Mr. Ralph Cooper, Mr. Dennis Wannemacher, Mr. Carroll Williams, Mr. Calvin Gross and Dr. Erwin Parson.

The panel was invited to help focus our attention on racial disparities in the veterans health care arena. The implications of these preliminary findings, as well as the urgent need to eliminate racial disparities in veterans health care led Congresswoman BROWN to call for the creation of a national working group to develop a series of legislative and policy recommendations to address these issues.

Our keynote speaker was Dr. Thomas Garthwaite, the Acting Under Secretary for Health at the Department of Veterans Affairs. Dr. Garthwaite stated that the VA is facing new challenges in the health care arena, specifically issues relating to veterans of African-American descent. He noted concerns in the area of long-term care, increased rates of Hepatitis C, behavioral and mental illnesses, and homeless veterans. He stated that these problems are compounded by a rapidly aging veteran population and a continued lack of sufficient funding for veteran-related expenditures.

Congresswoman BROWN and I agreed that funding for veterans health care is inadequate. We believe that we cannot have a budget surplus, if we have not paid our dues to America's veterans. Georgia State Senator Ed Harbison expressed the sentiment of many at the Braintrust when he stated, ''It used to be said, that 'old soldiers never die, they just simply fade away.' But in 2000, its more like 'old soldiers never die, they're just ignored to death!' ''

Dr. Erwin Parson, Vietnam veteran and health care professional, summarized the essence of the forum by acknowledging, ''We know too well that little attention has been given to the issue of African American elderly health by society. Our elderly veterans, especially our African American elderly, have important health care needs that are not being met satisfactorily. We are aware that the stream of scientific studies on comparative health seem to always reach the same conclusion: race is a factor in access and quality care for many life-threatening medical conditions which afflict African Americans.''

We found it disconcerting that studies found that race is often a controlling factor in the assessment and management of many administrative and clinical decisions in veterans health care. We all realize that accurate data is vital to evaluating the true health care needs of African American veterans. However, current research is much too sparse and fragmented. It is obvious that we urgently need to get better, more meaningful data on African American elderly veterans.

Finally, the reality is simply this: The aging veterans population is upon us now! We are grateful and will never forget that African Americans have fought gallantly for America, beginning as far back as the Revolutionary